Refer to: Where we stand—California Medical Association Position Papers on abortion, acupuncture, chiropractic, confidentiality, cost of care, drug abuse, environmental health, health education for the public, health in the United States, health quackery, health maintenance organizations and prepaid health plans, health manpower, national health insurance, physician's assistants, physician unions, professional standards review organizations, and quality medical care. Calif Med 119:42-59, Dec 1973

# Where We Stand

*To serve the interests of members and to function in the public interest, the California Medical Association must set policies and take positions on current issues affecting the health care of Californians. These policies then guide the activities of the Association in fulfilling its leadership role and its responsibility to the public.*

*Delegates, elected by the membership of CMA's component medical societies, meet annually to deliberate and determine the policies and courses of action for the Association. Between meetings of these Delegates, the CMA Councilors, elected by their district membership, implement the directives of the Delegates and set interim policies. By this democratic process, the membership governs the CMA.*

*Association members must be informed if they are to participate effectively in the affairs of their medical organizations. To disseminate better understanding of CMA's activities, position papers on current issues have been developed. They are based on House of Delegates resolutions and Council actions. Entitled "Where We Stand on Medical and Health Issues," these papers represent the current policy positions of CMA. Each paper is annotated to give the reference source of the policy actions.*

*As with any organization, CMA policies are subject to timely revision. When policies are amended or new policies are adopted, new papers will be developed.*

**Following are CMA position papers on:**

**ABORTION**
**ACUPUNCTURE**
**CHIROPRACTIC**
**CONFIDENTIALITY**
**COST OF CARE**
**DRUG ABUSE**
**ENVIRONMENTAL HEALTH**
**HEALTH EDUCATION FOR THE PUBLIC**
**HEALTH IN THE UNITED STATES**
**HEALTH QUACKERY**
**HEALTH MAINTENANCE ORGANIZATION AND PREPAID HEALTH PLANS**
**HEALTH MANPOWER**
**NATIONAL HEALTH INSURANCE**
**PHYSICIAN'S ASSISTANTS**
**PHYSICIAN UNIONS**
**PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS**
**QUALITY MEDICAL CARE**

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# Abortion



THE TERM ABORTION refers to "any procedure performed primarily for the purpose of terminating a pregnancy."

Today there is a wide divergence of opinion among lay persons and members of the medical profession on the subject of abortion. Is it ethical and moral for a woman to have an abortion if it is not strictly necessary for her physical or mental welfare? Is it ethical or moral for a physician to perform an abortion? Who has the right to make the decision? And at what point in the pregnancy? Although such questions remain either unresolved or a dilemma for many, abortion laws—once considered inviolable—have been liberalized in a number of states. In recent years, though public and legal opinion has moved in the direction of making abortion decisions a matter between physician and patient, the issue is still often hotly debated.

In January 1973, the United States Supreme Court lifted all restrictions on a woman's right to a physician-performed abortion during the first three months of pregnancy, saying that during the first three months, the decision to have an abortion lies with the woman and her physician; the woman has a "right of privacy" in which the State cannot interfere. It added that "the abortion decision in all its aspects is inherently and primarily a medical decision, and basic responsibility for it must rest with the physician." The court stressed that a physician cannot be required to perform an abortion if against his judgment or moral principles. The Supreme Court decided that states may "regulate the abortion procedure in ways reasonably related to maternal health" beginning with the fourth month of pregnancy.

### *CMA's Position*

The California Medical Association believes that abortion is a medical procedure governed by the Medical Practice Act and, as such, is a matter between the patient and her physician. In 1970, the California Medical Association's House of Delegates voted to adopt this policy, adding that abortion should "be governed by medical standards of sound clinical judgment and informed patient consent, according to the merits of each individual case[1]." As any other medical procedure, abortion should not be performed if it would be detrimental to the best interests, physical or mental, of the patient. Good medical practice indicates that abortion should not be performed after the 20th week of pregnancy.

CMA strongly opposes any factor that might lead patients into the hands of criminal abortionists, and therefore believes that abortions should "be performed in hospitals approved either by the Joint Commission on Accreditation of Hospitals or the California Medical Association Medical Staff Survey, or in appropriately equipped outpatient facilities demonstrating adequate mechanisms for local peer review.[2] Availability of such facilities to pregnant women seeking abortions decreases the number of illegal abortions and the risk to the patient's health.

Realizing that some physicians may disagree with CMA's position on abortion, whether for moral, ethical, medical or psychiatric reasons and acknowledging the wide spectrum of opinion on the subject, CMA believes that—as with any medical procedure, abortion should never be performed "on demand[3]." CMA holds that no physician may be required to violate his own conscience by performing an abortion, nor should any member of the health team be required to assist with an abortion, nor should a hospital be required to permit an abortion in violation of moral principles to which it is dedicated. The alternatives offered to members of the medical profession who oppose abortion are: "(1) to try to remove the stigma attached to pregnancy, (2) to provide emotional support to the patient during pregnancy, (3) to help in adoption, (4) to offer advice regarding future contraception or sterilization or (5) to withdraw from the case if the patient insists on an abortion, so long as the withdrawal is consistent with good medical practice[4]."

In all abortion cases, CMA urges the physician to provide pre- and post-abortion counseling and supports policy that recommends family planning counseling.[5]

CMA has established a standing committee "to consider the response of the medical profession to the evolving scientific, technological and philosophical trends in our society as they affect human life[6]." This committee has helped to evaluate policy on abortions, and is delving into other issues which concern society and its relationship to the medical profession.

REFERENCES

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. HDR 9-70; HDR 8-73; CA 5/1/70
2. HDR 189-73
3. HDR 9-70; HDR 8-73; HDR 9-73
4. HDR 9-73; HDR 9-70; CA 6/11/71
5. HDR 9-73; CA 7/28/72
6. HDR 8-73

## Acupuncture

THE RENEWED FOCUS of attention on mainland China during recent years has brought with it an interest in the practice of traditional Chinese medicine, particularly acupuncture. This technique, whose history dates back more than 1,000 years, involves the insertion of thin needles into various points of the body and claims results as an anesthetic, as a means of relieving pain, or as a cure for various ailments. After the acupuncture needles, which are about three inches long, are inserted one-quarter to one-half an inch into the skin, they are twisted, vibrated or moved up and down depending on the treatment. Chinese practice teaches that there are up to 1,000 acupuncture or sensitive points on the body's "meridians" where two or more needles can be inserted to produce the desired results.

### *CMA's Position*

The California Medical Association has urged a scientific evaluation of acupuncture "because of intense interest in the technique, which may have potential value in the relief of pain[1]." This action was followed by the introduction and passage of state legislation at the request of CMA which makes possible scientific studies of acupuncture and other forms of traditional Chinese medicine.[2] The law allows a non-physician to perform acupuncture, under a physician's supervision, in a California medical school for the purpose of scientific research. (Since acupuncture requires piercing of the tissues, it falls within the classification of "the practice of medicine" and therefore legally can be practiced only by licensed physicians and surgeons.) More recently, CMA opposed additional legislation authorizing expanded use of acupuncture in the state, pending receipt of a progress report on medical school evaluations of the technique.[3] Recognizing the widespread interest in acupuncture, the California Medical Education and Research Foundation, a non-profit subsidiary of CMA, has initiated a grant program to stimulate scientific investigation of the ancient technique in California's eight medical schools and the Charles R. Drew Postgraduate School of Medicine in Los Angeles.

REFERENCES

"CA" refers to CMA Council action

1. CA 5/19/72
2. CA 7/28/72
3. CA 1/5/73

## Chiropractic

CHIROPRACTORS DISAGREE among themselves on the definition of chiropractic. One group, known as the "straights," adheres basically to a rigid definition, holding that the sole route to restoration of health, no matter what the problem, is through manual manipulation of the spine. A second group, known as the "mixers," advocates the use of such modalities as heat, light, water, electricity, vitamins, colonic irrigation and other physical and mechanical adjuncts, in addition to spinal adjustments. Each group is represented by a national organization.

The chiropractic concept of disease is unsupported by scientific facts, and causes of infections and other diseases cannot be explained by the chiropractic theory that disease is caused by a "subluxation" (partial dislocation) in the spinal column. Many chiropractors claim to be able to cure everything from headache to cancer by spinal manipulation—although medical research has proved their claims impossible.

In regard to education, a study by the Department of Health, Education and Welfare notes ". . . irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment." Furthermore, no chiropractic school is accredited by any nationally recognized educational accrediting agency in the United States and chiropractic education is provided for the most part by chiropractors without a degree from an accredited college.

Forty-eight states impose license limitations on chiropractic, prohibiting chiropractors from pre-

scribing drugs and performing surgery. Two other states—Louisiana and Mississippi—do not issue even limited licenses.

The scientific community—including the medical profession—regards chiropractic as an unscientific cult, the largest group of unscientific practitioners in the United States.

### *CMA's Position*

CMA has emphasized repeatedly that chiropractic is an unscientific cult and that its practitioners lack the training and background to diagnose and treat human disease. Chiropractic is not a practice of medicine[1] and constitutes a hazard to health in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation. A patient who relies on chiropractic may delay proper medical care until serious and irreversible damage occurs. CMA pursues public recognition of this principle through public education campaigns and works to discourage chiropractic and other health cultism in all ways.[2]

The California Medical Association strongly disapproves of the payment of Medi-Cal, Medicare, Workmen's Compensation, Veterans Administration and other funds to chiropractors.[3] In addition, CMA has worked against inclusion of chiropractors in any insurance contracts.[4]


**REFERENCES**

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. CA 1/9/70; HDR 140-71
2. CA 2/5/71; HDR 140-71
3. HDR 85-68
4. CA 1/9/70


## Confidentiality

*Patient-Physician Communications, Patient Records*

FROM THE EARLIEST of times, confidentiality between doctor and patient has been considered a sacred trust, an essential aspect of the patient-physician relationship. An oath taken by Hindu physicians, 1,500 years before the birth of Christ touches on the subject. And the "Oath of Hippocrates," dating back more than 2,000 years, states: "Whatever, in connection with my professional practice . . . I see or hear in the life of men which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." Similarly, Article 9 of the American Medical Association's "Principles of Medical Ethics" deals with this matter of confidentiality.

However, in recent years—with the increase of third-party financing mechanisms, computerized data banks and the immense amount of detailed information requested by government, insurance companies and employers—confidentiality of patient-physician communications and patient medical records has been endangered.

### *CMA's Position*

The California Medical Association strongly opposes the "unethical requirements by third parties that highly confidential medical information be submitted without the patient's fully-informed consent." CMA's Committee on Insurance and Prepayment has been instructed to meet with representatives of the insurance industry to explore means to correct this problem.[1] Similar action has been taken to establish methods of specifically safeguarding the confidentiality of patient hospital records.[2] And, at CMA's request, legislation recently was introduced in the State Legislature—as SB 447—to guarantee confidentiality of patients' medical records in a wide variety of circumstances.[3]

CMA also has sought action from the insurance industry to minimize the amount of patient medical information necessary for insurance reports, and to establish channels of handling this information within an insurance company so that only the medical department of that company has access to it.[4]

Because confidential medical reports sometimes have been made known both directly and indirectly to employers—to the possible detriment of patients—CMA also sought action to prohibit the use of medical information for any purpose other than the evaluation of the specific insurance claim in question, and to withdraw approval of the all-inclusive blanket consent form that patients sign when they apply for insurance benefits.[5]


**REFERENCES**

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. HDR 128-73
2. HDR 10-70
3. CA 10/27/72
4. HDR 39-71; HDR 31-72
5. HDR 33-72

## Cost of Health Care*

ESCALATING COST is the most criticized and least understood aspect of health care in America today. In this regard, we cannot emphasize too strongly that health care and medical care are not the same thing.

Medical care—services provided by physicians—is only one part of health care, along with such other components as hospitalization, nursing, dental care, drugs, nursing home care, eyeglasses, etc. Physicians' services account for about 20 percent of all health care costs, while hospital costs account for nearly 40 percent. The rate of increase for physicians' services, furthermore, has been considerably less than the overall rate of increase for health care. In fact, most recent statistics show that the cost of physicians' services—medical care—has been rising at a lower rate than the cost of living.

Why have hospital costs increased so markedly? The primary reason is that hospitals are a service that necessarily involves a high ratio of employees to patients. Labor costs represent about 70 percent of a hospital's total expenses, compared with 25 to 30 percent for other industries. Until recently, nurses and other hospital employees have been notoriously underpaid. As their salaries have risen to more realistic levels, hospitals have had to raise their rates accordingly.

In the future, technical and medical advances will permit even greater feats of life saving than are possible today. But the cost also will be greater, since ever more complex equipment and higher worker-patient ratios will be required.

Physicians certainly are concerned with these rising costs. They keep a close check on them through "utilization review," a process to assure the propriety of doctors' billings to health insurance carriers (see the "Quality Medical Care" section on peer review). Physicians and their medical organizations also seek innovative methods to keep a rein on rising costs; Sacramento's CHAP (certified hospital admission program) and Fresno's Medi-Cal Intermediary Operations are examples of programs that are successfully keeping health care costs down.

But as physicians, our primary concern must continue to be what it always has been—the health of our patients. Therefore, our emphasis must remain on seeing that our patients receive the best possible health and medical care.

*See also Health in the United States.

## Drug Abuse

DRUG ABUSE has become a pressing problem in today's society. Drugs of abuse are defined as "those drugs which produce mood alteration or mind alteration"—those drugs which are psychoactive. The term drug abuse applies to the "use of any drug by an individual to the extent that it adversely affects or limits his ability to function as a responsible person."

### *CMA's Position*

California Medical Association recognizes the extent of the drug abuse problem in our society. CMA has a committee on alcoholism and drug dependence that helps physicians use effective medical countermeasures to the problems of drug abuse and that provides the medical profession with current expert opinion on the subject. The committee also helps educate the public about the dangers of drug abuse.

In 1972, the CMA Council launched a renewed attack on drug abuse in California through a pilot program to increase the ability of physicians to treat drug-dependent patients. The program covers MDs' education and training in diagnosis, treatment and referral to other community health services of patients who abuse drugs, including alcohol.[1] CMA feels strongly that when a person "shows medical indications of physical or psychological dependence on any drug, that person should receive competent medical care." The Association urges the establishment of training programs in medical schools, in community hospitals and at postgraduate levels with extension of training to nurses and paramedical personnel dealing with drug abuse.

In a recent report, the committee listed the drugs of abuse in the order of their physical damage and psychological and socioeconomic disruption. CMA ranks alcohol as the most destructive drug of abuse. Following it, in decreasing order, are barbiturates, amphetamines, heroin and other narcotics, cocaine, hallucinogens, marijuana and hashish, solvents (airplane glue and paint thinner) and tobacco.

"Alcohol abuse is the most serious form of

drug abuse in our society today—even more serious than heroin addiction, when evaluated in terms of organ damage, the effect on the user's overall health, societal disruption and association with criminal behavior or total population involved[2]," says CMA. Although CMA does not recommend prohibition of alcoholic beverages, it advocates "intensive public education, in all grade levels and through the mass media, concerning the harmful effects of alcohol," and asks the mass media not to present alcohol in such a way that promotes its use as a mood-altering drug. CMA also strongly believes alcohol must be recognized and treated as a disease that has become a public health concern of major proportions, and that insurance coverage should not exclude the treatment of alcoholism nor place restrictions on the coverage provided, except as those restrictions may apply to any other medical illness.[3]

Because of the increasing abuse of barbiturates and other sedative hypnotics (central nervous system depressants used to treat insomnia and to relieve anxiety) and amphetamines (central nervous system stimulants used to treat certain hyperactive, neurologically-impaired children, to suppress appetite and to ward off fatigue), CMA alerted the county medical societies to the crisis. CMA recommended that "every physician limit the prescription of these dangerous drugs to the minimum quantity consistent with the immediate medical indication[4]."

In its attitude toward addiction to heroin, opiates and other narcotics, CMA asserts that "irrespective of how addiction develops, it is a disease which requires medical services and social rehabilitation. The medical aspects of the disease must be separated from the criminal aspects of the behavior and legal status of the individual patient, so that treatment may be readily available to every addict who seeks it[5]." Because in- and outpatients detoxification clinics, halfway houses and methadone maintenance programs all have been successful to some degree in treating the addict, CMA encourages their availability in sufficient numbers, realizing also that attention must be given to resocialization in an attempt to replace the psychological dependence and establish the individual's personal stability.[6]

Cocaine, used medically as a topical anesthetic, is increasingly used illicitly as a central nervous system stimulant. CMA strongly warns that such continued usage leads to deterioration of health because of nervous fatigue, nutritional deficiency and psychosocial defects and to psychological dependence in the habitual user.

Hallucinogens or psychedelics and marijuana and hashish should undergo intensive scientific investigation to discover their long-range effects, their potential social uses and their value as tools in clinical medical practice.

Marijuana's long-range effects are not known, and CMA encourages research and clinical trials. CMA feels that legalization of marijuana is an issue for society to decide. However, CMA recommends reduction of penalties for possession of marijuana for personal use, because the effects of imprisonment and a felony conviction could create great mental and physical stress. The penalties for the possession of marijuana for personal use, even in private, have imposed criminal status on many persons who otherwise have evidenced no criminal or antisocial behavior.[7]

Inhaling the fumes of solvents can cause mild intoxication, acute disorientation or death. Repeat users may have medically treatable psychosocial problems. The dangers of experimentation with solvent inhalation must be countered by education.

Tobacco is not generally considered a drug of abuse. However, most people are now aware of the direct correlation between cigarette smoking and lung cancer. Even more significant, in numbers of people killed and disabled, are cardiovascular disease, bronchitis and other chronic pulmonary diseases caused by cigarettes. While supporting each person's right to freedom of choice, CMA condemns the use of tobacco as one of the most physically destructive forms of drug abuse in our society today. CMA recognizes the rights of non-smokers to breathe air free from cigarette smoke. CMA encourages individuals to give up the smoking habit, and advocates intensive public education in all grade levels and through the mass media concerning the harmful effects of smoking.[8] CMA's House of Delegates adopted a resolution to discourage smoking in public areas, public transportation, CMA offices and meetings, in all health care facilities; and to endorse a team approach for helping individuals who want to quit smoking. CMA also will develop a placard for physicians' offices saying, in effect, "For your health and the health and comfort of others, we thank you for not smoking[9]."

Drug abuse is not a single, simple issue. It is a collection of many complex, interrelated psychological, physical and social problems not isolated from the other problems of our communities, such as unemployment, housing, education, police relations. Since many aspects of these problems are unique to each locality, local action and involvement are necessary to confront them. California Medical Association recommends the establishment of sound, comprehensive treatment programs for drug abusers in which the whole community actively contributes to social readjustment.

**REFERENCES**

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. CA 10/27/72
2. CA 2/9/73
3. CA 2/9/73; Approved by House of Delegates
4. HDR 89-69
5. CA 2/9/73; Approved by House of Delegates
6. CA 2/9/73; CA 5/19/72; Approved by House of Delegates
7. CA 2/9/73; HDR 10-73
8. CA 2/9/73; Approved by House of Delegates
9. HDR 68-73

## Environmental Health

POLLUTION OF OUR ENVIRONMENT has become an increasingly severe problem of concern for both public and private agencies, as well as individual citizens. The term "environmental health" is used in discussing specific aspects of this problem, such as air, water and soil pollution, but also includes health factors related to population growth, urbanization and technological developments bearing on the quality of life.

The scope of the problem is great. For example, the effects of air pollution on man are serious and can even be fatal; acute episodes of air pollution have caused increased rates of death and disease, especially among the very young and elderly and among persons with preexisting respiratory or cardiac conditions. The immediate threat to human health by waterborne infectious pathogenic agents and toxic materials does not need to be elaborated. Although comprehensive, verifiable data are lacking because specific health costs are difficult to identify and measure, health costs in the United States for environmentally-induced disease have been estimated at an annual rate approaching $40-billion. These costs probably will continue to rise.

### *CMA's Position*

Environmental health is a legitimate concern of the medical profession, and CMA has emphasized repeatedly that overpopulation; pollution of our air, water and land; and other environmental problems have resulted in an "ecological crisis[1]."

Conservation of natural resources is considered an activity and concern of every committee and commission of the California Medical Association and a basic element of CMA's goals.[2] Thus, we have determined to "assume appropriate leadership . . . to achieve recovery and maintenance of an ecologically healthy environment" through (1) educating the medical profession and the public,[3] (2) legislation and (3) encouraging county medical societies to establish environmental pollution control committees[4] and become involved in local ecological activities.[5]

To deal with the serious problem of air pollution, CMA encourages mass transportation, stringent air pollution standards, use and inspection of vehicle emission control devices,[6] mandatory emission inspection and conversion of fleet vehicles to alternate fuels in high-risk areas[7] and use of health warning systems to alert area residents when air pollution levels increase or endanger health.

Noise pollution is another threat to environmental health recognized by CMA. We have urged Congress to allow states more stringent noise pollution standards than federal ones, have supported stringent standards for California, have backed appropriate noise control legislation and supported establishment of noise criteria for California.[8]

CMA urges that the citizens and state government of California endorse the "Environmental Bill of Rights" developed in 1970 by an Assembly select committee,[9] supports the concept of a central state agency for environmental quality,[10] and backed the 1972 California initiative on preservation of coastal lands (Proposition 20).[11]

In regard to the public health dangers of tobacco smoking, CMA discourages smoking in public areas, public transportation and health facilities;[12] and supports a ban on all cigarette advertising.[13]

Some other environmental protection measures supported by CMA: population growth, including family planning clinics; research and action to prevent contamination of our oceans and waterways; adequate sewage and solid waste disposal; use of recyclable and biodegradable products; rat

control; maintenance of recreational areas; open-space standards for metropolitan areas,[14] and research funding to assure that nuclear energy development takes environmental factors into consideration.[15]


**REFERENCES**

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. HDR 25-70
2. HDR 40-72
3. HDR 26-73
4. CA 11/4/67
5. HDR 25-70
6. CA 4/6/72; CA 7/28/72; CA 9/22/72
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8. CA 7/28/72
9. HDR 25-72
10. CA 4/6/72; HDR 24-72
11. CA 9/22/72
12. HDR 152-71; HDR 68-73
13. HDR 65-71; HDR 123-73
14. HDR 69-73
15. HDR 71-73


## Health Education for the Public

HEALTH EDUCATION is designed to inform and motivate the individual toward practices that will result in optimal health. It goes beyond the systematic transmittal of knowledge that promotes, improves and maintains individual and community health. To be successful, health education also must induce people to apply health information to life and living. The goal of health education is to achieve fundamental changes of life style—away from patterns that contribute to sickness and early death, and toward new patterns that promote good health.

### *CMA's Position*

The California Medical Association has a long history of involvement and commitment in regard to health education for the public. The association currently has a dozen active committees whose primary thrust includes public education as a means of preventing illness and maintaining health. Their names encompass the most pressing health problems of our time, including alcoholism and drug abuse, venereal disease, traffic safety, disaster preparedness and environmental health.

To cite a specific example of work by a CMA committee, our Maternal and Child Care Committee is currently engaged in a program designed to reduce perinatal mortality. Health education plays a major part in this program, stressing the need for prenatal care and personal nutritional education.



An important part of CMA's health education effort is in the area of school health. Our committee on School and College Health sponsored and helped write the "State Framework for Health Education" and the administrative guidelines for its implementation.[1] For more than 15 years this committee also has sponsored many educational programs for professional and lay groups—including school health congresses at CMA's annual session.

CMA's pioneering public education project, "Health Tips," is a further example of CMA activity in this field. These concise statements on specific medical and health subjects, written and approved by panels of medical experts, are distributed on request to more than 6,000 outlets, including nearly 4,000 key school personnel, various news media, public health agencies, physicians and county medical societies. County medical societies and schools—kindergarten through universities—use the material in a variety of ways: duplication and distribution to students and parents in entire school systems, health education course syllabi; health text books, teacher and school nurse education and health fairs. More than 300 subjects have been covered by the four monthly "Health Tips," and many have been translated into Spanish for California's Chicano population.

CMA fills more than 100 monthly requests by schools for films on various health subjects; produces television news films, "Health Hint" public service announcements for radio and news releases for all media; and assists county medical societies with health fairs and exhibits.

CMA also has worked to encourage county medical societies to establish active liaison with local school systems, to provide lectures on appropriate subjects in both the public school system and colleges; and to have physicians and other health professionals make themselves available as consultants and resource people.[2]

Most recently, the CMA Council approved further actions designed to improve public health education. These include: (1) establishing a permanent committee of CMA's Scientific Board on health education for patients and the public, (2) launching an extensive survey of public health

educational needs and the adequacy of available resources and (3) exploring methods to encourage physician involvement in health education in the local community.[3]

REFERENCES

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

1. CA 6/27/69
2. HDR 96-71
3. CA 2/9/73

## Health in the United States*

THE PHRASE "health care crisis" is frequently heard in reference to American health care. It appears with some regularity in political speeches and in news media stories.

It is true that improvements in the health-care field are both needed and possible. Undoubtedly, greater efficiency without loss of quality or even with increased quality is possible in some aspects of health care. Better geographical distribution of available medical services—particularly in urban ghettos and rural areas—is needed. And various government health programs need improvement.

However, none of these factors constitutes a "health care crisis." People are not waiting in vain for health care in hospitals, physicians' offices and pharmacies. People are not dying in the streets of our cities for lack of health care. The United States does not have skyrocketing mortality and morbidity rates. These are factors that really would constitute a true crisis—and they do not exist.

### *Comparing International Health Statistics*

Many proponents of the "crisis" theory point to comparisons of selected health statistics for the United States and some western European countries. Our nation's infant mortality rates, they point out, are higher than in some of the smaller European nations, and our statistics for life expectancy are not as good.

But the fact is that comparing such health statistics does not measure the effectiveness or quality of a nation's health care system, nor does it provide an accurate picture of its state of health. For one thing, the relative position of a country in regard to health statistics depends on which statistics are chosen. For example, Sweden is cited for its low rate of infant mortality (also see "root causes of poor health" below). But Sweden also leads most other nations in the world in its rates of death from such causes as pneumonia and stomach ulcers.

In regard to infant mortality statistics, the countries usually compared with the United States have small and relatively homogeneous populations, while the U.S. is a melting pot of various races, cultures and educational and economic attainments—all of which affect health.

Furthermore, the various nations of the world use different bases for reporting their health statistics. In the United States, we count a birth as live if there is any immediate sign of life, while some countries require survival for a year for the birth to be considered live. If we consider areas of the world truly comparable to the United States—Western Europe as a whole or the Soviet Union—our infant mortality rate emerges as superior.

### *Root Causes of Poor Health*

Environmental and socioeconomic factors have a greater impact on a nation's health than medicine alone does. Such causes of death as lung cancer, cirrhosis of the liver, homicide, suicide and automobile accidents are significant factors in this nation's mortality rates. Lung cancer deaths could be cut drastically by a sharp reduction in cigarette smoking. Cirrhosis of the liver could be reduced by a lowered consumption of alcohol. Automobile accidents and death would decrease rapidly with better safety devices and stricter highway law enforcement. None of these problems of society can be solved medically.

Similarly, most studies of high infant mortality indicate that the causes are rooted in poverty, malnutrition and lack of education. Infant mortality, in fact, correlates best with the level of education achieved by the mother. The relatively spectacular drop in rates of infant mortality in this country in the recent past can be attributed in large part to the improvement in income and education from which many poor Americans have benefited since the mid-1960s.

In short, a major portion of America's health problems stem from such non-medical causes as poor housing, poor nutrition, inadequate income and education—and unhealthy lifestyles. Doctors can only treat the symptoms; the medical profession cannot eliminate the root causes of these

*See also Cost of Care.

health problems. This calls for a massive effort on the part of our entire society, involving individuals as well as local, state and federal governments.

### *How Good Is American Medical Care?*

Since comparing international health statistics is misleading, what is a good way to measure how effectively a health care system meets the needs of the people? We believe that the yardsticks by which good medical care can be measured most meaningfully are general health, growth and development; improved life expectancy; eradication of infectious disease and such contagious diseases as poliomyelitis, tuberculosis, typhoid fever and tetanus; advances in medical and surgical techniques for the early detection, treatment and cure of heart disease, stomach ulcers, cancer and other killer diseases. By all of these standards, medical care in this country excels.

## Health Quackery

HEALTH QUACKERY has been variously defined, but generally is understood to be "the pretension of practice of a boastful pretender to skill which he does not possess, especially medical skill." The entire spectrum of people needing health care may be involved—from the terminal cancer patient, to the person looking for a quick and easy way to lose excess pounds, and even to the food faddist. Some forms of health quackery cause direct damage to health. Many other forms of health quackery endanger the person's health by delaying proper, scientific medical care.

### *CMA's Position*

From its inception, the CMA has combatted health quackery as a part of CMA's constitutional mission "to protect the public health . . . "

In recent years, CMA sponsored the pioneering 1959 law to protect the public from cancer quackery and in 1967 backed legislation that made California the first state to treat medical quackery as a felony.

Despite this effective legislation, health quackery persists. Cancer quackery, for example, continues to result in tragedy because of delayed or improper treatment of cancer. The medical profession strongly condemns such cancer quackery as the Hoxsey method, Laetrile, the Bolen test, Koch agents, Lincoln Staphage Lysate, Mucorhicin, the Anthrone test and Krebiozen.

The California Medical Association and its component (county) medical societies continually seek to educate the public on the dangers of health quackery and to provide leadership in combatting this hazard.

## Health Maintenance Organizations and Prepaid Health Plans

A HEALTH MAINTENANCE ORGANIZATION (HMO) or prepaid health plan (PHP) can be broadly defined as an organization that contracts to furnish a wide range of health services, both professional and institutional, for a specified population, and is paid a fixed monthly or annual sum per person covered for such services.

Services may be provided either by the organization itself or by arrangements between it and other providers. Basic services that must be provided are not fully determined, but must include physicians' services, inpatient hospital care, and some outpatient services. Under various definitions, it may also include extended care facility services, home health services, emergency care and preventive services. Existing prototypes are the Kaiser Foundation health programs and certain union and railroad health programs.

Plans may be sponsored by a wide variety of agencies, including hospitals, medical care foundations, medical schools, industry and insurance companies. While the total care is to be paid for on a capitation basis, individual providers need not necessarily be paid on this basis. HMO/PHP proponents believe that the fixed operating budget for all health care will encourage the use of the most economical adequate source of care.

### *CMA's Position*

The California Medical Association supports a pluralistic approach to the delivery of medical services, and continues to encourage innovation in the organization and delivery of health care services.[1] CMA considers HMO one such approach; for certain population groups or residents of certain areas, they may provide an alternative means of obtaining health care. However, their develop-

ment must not be allowed to destroy traditional forms of private medical practice. Patients must continue to have a right to choose the method of receiving care they prefer.

Before any long-term commitment is made to the HMO concept by government, at either the state or the federal level, HMOs must be carefully evaluated in actual operation on a pilot basis. These studies should produce statistical evaluation of cost-effectiveness and critical review of the quality of care provided by existing HMO organizations encompassing at least a two- or three-year period.[2] Pending these results, CMA urges a moratorium on further federal HMO funding[3] and requests the California Legislature to prohibit further HMO contract awards by the Department of Health Care Services.[4] To assist the Legislature in evaluating HMO contract programs —both in terms of quality of care and cost effectiveness—CMA will make available whatever may be required in terms of peer and utilization review expertise.[5]

In regard to HMO contracts awarded by the state, CMA notes that future emergency funding or higher capitation rates may be found necessary to maintain the viability of HMO programs. To provide such assistance and subsidy to this single health care delivery approach and not to others would constitute preferential treatment for HMO contractees and is opposed by CMA.[6]

CMA also points to certain areas in which the Legislature and Congress should regulate HMOs. These include: (1) Approval of need for an HMO by the county medical society or the local comprehensive health planning association; (2) Requirement of substantial physician representation on an HMO's governing body; (3) Requirement that HMOs be regulated as insurers of health care services; (4) Control of HMO's advertising—i.e., treat them as other practitioners of medicine; and (5) Government subsidization only in direct relationship to the number of non-paying patients cared for.[7]

The CMA, working through three of its commissions and committees (Medical Services, Medi-Cal, Peer Review) and in conjunction with four prepaid group practice plans and representatives of several foundations for medical care, developed a list of 24 criteria to be applied in the evaluation of prepaid health plans under Medi-Cal. It is the purpose of these performance criteria to assure that organizations contracting to provide medical services to Medi-Cal recipients can and will provide and maintain the quality of such services.[8]


**REFERENCES**

"HDR" refers to CMA House of Delegates resolution
"CA" refers to CMA Council action

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2. HDR 116-72; HDR 161-72; HDR 127-73
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4. HDR 127-73
5. HDR 127-73
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## Health Manpower

THE SUBJECT of health manpower has received public attention in recent years because of theories that the United States suffers from a "health manpower shortage," particularly a "doctor shortage."

Whether there is an absolute shortage of physicians, or whether problems are essentially ones of distribution, specialization and inefficient utilization, however, remains a moot question—as does the question of what, indeed, represents an adequate physician supply. The topic was confronted in 1972 by the California Medical Association's House of Delegates, which adopted a resolution entitled "Physician Shortage—Myth or Reality[1]."

According to the President's manpower report to Congress last year, by 1980 there will be about 444,000 physicians in this country—enough to eliminate shortages, if in fact they exist. This figure represents a predicted 10-year increase of 120,000 physicians under present educational approaches, as a result of predicted expansions of medical school enrollment and accelerated training. It should also be noted that America's physician population is increasing at a rate three times that of the general population.

### *CMA's Position*

California Medical Association's Division of Socioeconomics and Research recently completed a three-part study—at the direction of the CMA Council[2]—centering on physician supply in California.[3] This study notes that one physician per 650 to 750 persons probably represents a satisfactory, although not necessarily an optimal, level. It further states: "In California, the current figure is one physician per 609 persons. While this cannot be used as absolute, irrefutable evidence that

overall statewide shortage does not exist, it strongly suggests that this is the case."

On the national level, the findings of CMA's study seem to agree with the President's manpower report mentioned above: "Nationally, there remains some degree of absolute shortage of physicians with a ratio of one per 779 persons. At the current rate of production of physicians, compared with population growth rates, the gap should be closed within the next few years."

Nonetheless, it is a fact that people living in the poorer sections of many cities and those living in rural areas isolated from cities and towns often do not have ready access to a doctor. Clearly, then, a major health manpower problem is maldistribution of physicians.

CMA is working toward alleviation of this problem in California through our Physician Placement Service, created specifically to "match" physicians with locations where opportunities exist and where medical services are needed.

In order to assist areas that have a physician shortage, CMA also supports legislation to grant income-tax credits to medical practices established in such communities and areas.[4] In other activities, a CMA consultation service is being created through our Commission on Health Manpower to help identify and solve problems relating to the accessibility of care in both urban and rural areas. This service will stimulate county societies to identify gaps in their areas' health care delivery systems and will help them develop realistic solutions to these shortcomings.

Through the California Medical Education and Research Foundation (CMERF), a nonprofit corporation supported by CMA, the association is able to provide financial assistance for innovative local medical care programs in their early phases of development. In addition, CMERF often is called upon to help county medical societies develop grant applications for funds from private and public sources. Recent examples of such grant applications include financing programs of health insurance for migratory workers and evaluating the effectiveness of neighborhood health centers.

Furthermore, CMA is giving college scholarships to many deserving students, particularly blacks, who plan careers in the health field. And we are urging medical schools to expand their enrollments and to seek out and financially assist interested and potentially qualified minority students who desire educations in the health fields.[5]

To further alleviate the health manpower problem, the association is working toward establishing the new occupation of "health care assistant," also known as "physician's assistant." In cooperation with other interested organizations, CMA has developed criteria for the education of this new category of health worker, worked on legislation for their certification and studied means for recruitment and employment.[6] To assure that education and utilization of health care assistants serves the best interest of quality patient care, CMA emphasizes that all new health assistant categories and programs should be reviewed by CMA's Commission on Health and Scientific Board.[7]

CMA's commitment to an adequate supply of health manpower to meet California's future needs is underscored by our active campaign on behalf of Proposition One in 1970, which failed, and Proposition Two on the November, 1972, ballot, which voters approved. CMA contributed staff and financial assistance toward the passage of these bond issues to upgrade and expand the state's medical schools and other health manpower training facilities.


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3. Socio-Economic Reports, Vol. XIII, numbers 1, 2 and 3
4. HDR 2-72
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7. HDR 2-73
8. CA 2/16/72; CA 5/19/72


## National Health Insurance

THE TERM "national health insurance" has been applied to a wide range of proposals dealing with the financing and delivery of health care in this country. Since these proposals differ greatly among themselves, the term "national health insurance" (NHI) cannot be strictly defined. However, common to all of these proposals is the use of some form of insurance, private or social, to pool the financial risk of needed health services and the use of some form of federal taxation to assist in paying for the services or for the insurance.

In general terms, the major current proposals can be classified either as private insurance approaches, such as the American Medical Asso-

ciation's Medicredit plan, or social insurance proposals, such as the Kennedy-Griffiths-AFL/CIO bill. As would be expected from their use of the private insurance approach, the former proposals involve less compulsion and more choice than the social insurance proposals. The social insurance plans would mandate inclusion of the entire population; the private insurance proposals could include everyone, but individuals might choose not to participate.

AMA's Medicredit would cover the lower-income group in full, with income-tax incentives to all other persons to encourage the purchase of comprehensive basic health insurance coverage. Insurance premiums for protection against catastrophic health expenses would be paid in full, without regard to income level.

The social insurance plans would pay for virtually all services, while the private insurance plans would set minimum basic benefits and allow a purchaser to select these or greater benefits at his option.

Administration and financing of the proposals varies widely. The estimated costs differ accordingly, from about $40 billion to more than $80 billion for the social insurance programs, to low and high cost estimates of $8 billion to $17 billion for Medicredit.

Both types of proposals would provide financial access to the health care system, but from opposite positions as to the rights and responsibilities of the individual and government. The social insurance proposals would give almost total financial control of the health care system to the federal government and subordinate the rights and responsibilities of both patients and health care providers. The private insurance programs would provide the individual with financial access to the system and make governmental intervention subordinate to the individual's decision.

### *CMA's Position*

CMA believes that physicians must assume the responsibility for making sure their patients get the kind of medical and health care they need and want. Patients must not be forced into an assembly-line health care system that does not recognize that medical care, in the final analysis, is one sick patient treated by one physician he trusts. Consequently, CMA repeatedly has voiced strong opposition to any policy of *compulsory* national health insurance.[1]

Recognizing the individual as the important focus in the health care system, CMA in recent years has developed a number of principles deemed essential to any program of national health insurance.

First is adequate coverage for all. Everyone should be able to get the health care he needs; no one should lack health care simply because he cannot afford it.[2]

Second is complete freedom of choice.[3] Freedom to join or not join the plan.[4] Freedom to choose one's own doctor and health facility.[5] And freedom for the doctor to give sound medical treatment without bureaucratic interference.[6] In addition, confidential physician-patient relationships must remain inviolate and without third party interference.[7]

Third is comprehensive health care. In addition to adequate standards for hospital and medical care, any plan should cover outpatient services, prescriptions, dentistry and nursing care. Catastrophic illnesses must be covered to avoid financial ruin for patients.[8]

Fourth is sensible financing. Financing medical care through the voluntary, private insurance approach is the means whereby individual freedom and responsibility can best be assured, but prepaid closed-panel plans should be available as an option.[9] Government assistance should be provided to those unable to pay for medical care.[10] For others, government might pay part or none of the costs, depending on income.[11] "Usual, customary or reasonable" fees should be paid providers of health care.[12] There should be no duplication of health care coverage. Just as personal health care insurance plans cannot provide duplicate benefits to subscribers, so no government-sponsored program should duplicate that provided through employment. Multiple coverage for the same individual is inappropriate.[13]

Fifth is innovative care. No NHI plan should be locked into any one health care system. New ways to deliver care should be encouraged within a pluralistic system, so doctors can meet the medical needs of the future.[14]

A sixth point concerns pilot projects. We have seen what upheaval can be caused by government health care programs implemented nationwide without prior testing to determine their effect both on the health of patients and on the soundness of the health care system. Therefore, we believe that

experimental programs such as health maintenance organizations (HMO's) and others should be tried on a pilot basis.[15] Demonstration and experimental programs should involve both local medical societies and consumers.[16]

Seventh is professional standards. Medical professionals must establish standards for the care received by the patient[17] and must monitor that care to evaluate both quality and appropriateness of charges.[18] Professional medical organizations have the training and experience to do this; government does not.[19] In addition, CMA believes that the same mechanism and standard of peer review must apply for all methods of medical care delivery; the peer review committee must be under the control of the local medical society, and its decision must be binding.[20] Further to assure quality care, institutions should be accredited and utilization review committees maintained.[21]

Eighth is knowledgeable planning. CMA feels that practicing physicians must be represented effectively in decision-making on all governing boards and at all administrative levels involving medical care delivery.[22]

CMA believes these principles are medically sound and socially progressive. They encompass a realistic view of what is fiscally feasible in making health care available, without placing unrealistic burdens on the wage earners and businesses of the nation. Of all the national health insurance proposals currently being considered, AMA's Medicredit plan comes closest to complying with CMA principles. Consequently, CMA officially endorses Medicredit.[23]


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"CA" refers to CMA Council action

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18. CA 7/17/70; HDR 20-70
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## Physician's Assistants

IN SOME AREAS of America it sometimes can be difficult to obtain health care services. One reason is a shortage of physicians, particularly family physicians, in some rural and inner city areas.

To help overcome this problem, a new type of health worker, the physician's assistant, is being developed. In the health manpower pyramid, the physician's assistant is below the physician and above the registered nurse. Creation of this new type of health worker assumes that many of the physician's more routine duties can be effectively assumed by a lesser trained health worker, freeing the physician to treat the more complex medical problems of a larger segment of the population. Physicians utilizing physician's assistants also are freed to master new skills made possible by new developments and expanded knowledge and technology in medicine.

Several educational programs for the physician's assistant have been developed and others are currently being formed in California, each required by AB 2109 of 1970 to have the approval of California's Board of Medical Examiners.

As a graduate of the approved program, the physician's assistant, under the responsibility and supervision of the physician, should be able to perform such duties as taking a "complete, detailed and accurate history; performing a complete physical examination excluding pelvic and endoscopic examination; and recording and presenting pertinent data in a meaningful manner to the physician. He should be able to perform and/or assist in the performance of routine laboratory and screening techniques such as blood tests, urinalysis, taking of cultures, performance and reading of skin tests, and the taking of electrocardiograph tracings, in addition to being able to give injections, immunizations, removal of sutures and casts, application of traction, removal of foreign bodies from the skin, incision and drainage of superficial skin infections, and strapping, casting and splinting of sprains. He should be able to recognize and evaluate situations calling for immediate attention of the physician, instruct and counsel patients in certain matters, assist in hospital admissions and in the physician's office in the ordering of drugs and supplies, record keeping, and the upkeep of equipment, assist the physician in providing services to patients requiring

continuing care, and facilitate the physician's referral of patients to appropriate health facilities, as well as have an understanding of the socio-economics of medicine, the roles of various health personnel and of the ethics and laws under which medicine is practiced and governed."

### *CMA's Position*

Recognizing the shortage of physician manpower in California, the California Medical Association sees the role of the physician's assistant as one possible solution to the situation. For more than three years CMA has studied the assistant's functions and effects on the quality of health care delivery.[1] "To insure that the role of the physician's assistant is directed toward enabling the physician to work more effectively and not toward developing unqualified and insufficiently trained 'second class' practitioners,[2] CMA's Commission on Allied Health Professions has been charged with the task of assisting the Board of Medical Examiners in developing criteria for the physician's assistant[3]."

CMA urges that the physician's assistant remain under the direction of a physician, "be certified with some mechanism of recertification including peer and specialty review," and be so identified to patients.[4]

CMA strongly affirms that the physician's assistant shall neither restrict a physician's medical practice management and judgment nor shall he abridge the physician's authority to use and direct allied health personnel in accordance with sound medical practice.[5]

Concerned with establishing and maintaining high criteria for medical training and educational programs for the physician's assistant, the House of Delegates directed CMA's Commission on Health Manpower and Scientific Board to review and consider for approval all new health assistant categories and programs in California before their implementation by any educational institutions.[6]

The shortage of health manpower is of grave concern to CMA, and continuing efforts have been directed at relieving this shortage. Because CMA realizes that physician's assistants are only one answer to the problem of health manpower shortage, CMA continues to seek additional solutions—the prime purpose being improvement in the quality of health care services.[7]

**REFERENCES**

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"CA" refers to CMA Council action

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5. HDR 7-72
6. HDR 2-73
7. CA 6/11/73

## Physician Unions

"PHYSICIAN UNION" is a general term covering a variety of organizations that seek to apply union techniques in representing physicians. Recently, a number of these groups have sought to include dentists as well. Some physician unions have chosen to affiliate with organized labor but most have avoided this step.

Arising at a time when government and insurance plans exert growing influence, the physician union movement is concerned primarily with members' economic interests and their frustration with "third party" intrusion into the doctor-patient relationship. Many physician-union leaders feel that such traditional organizations as the American Medical Association and the American Dental Association are doing excellent work in the fields of professional standards, postgraduate education and medical and dental ethics. However, they state that there has been too little militancy in socio-economic matters.

### *CMA's Position*

The California Medical Association recognizes the right of its members to join physician unions and desires to maintain continued communication with these organizations.[1] However, in regard to using organized labor's tools of striking, boycotting or withholding services, the CMA House of Delegates has emphasized repeatedly that such actions are unacceptable and unethical for the medical profession.[2]

More generally, CMA has noted that existing antitrust laws would seem to prohibit organizations of self-employed persons from engaging in collective bargaining. Since most practicing physicians today are self-employed, this factor would appear to limit physician unions legally to the same activities presently undertaken by organized medicine.[3]

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"CA" refers to CMA Council action

1. HDR 21-73
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# Professional Standards Review Organizations



THE SOCIAL SECURITY AMENDMENTS passed by Congress in 1972 included the Bennett Amendment that established professional standards review organizations (PSROs). These peer review mechanisms are designed to "promote the effective, efficient and economical delivery of health care services . . . and to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made (for Medicare, Medicaid and Maternal and Child Health Programs) will conform to appropriate professional standards for the provision of health care."

The Secretary of Health, Education and Welfare is empowered to contract with "qualified organizations" to establish PSROs for a trial period of up to two years. After January 1, 1976, the secretary may contract with other organizations, if he finds that local professional groups were unable or unwilling to perform the review function.

To be designated a PSRO, an organization must be deemed by HEW to be "qualified"—a nonprofit, professional association with a voluntary membership of licensed doctors of medicine or osteopathy (usually 300 or more) who are practicing medicine in the area and who are not required to pay dues to any organized medical society as a condition of PSRO membership.

The PSRO must determine whether services are medically necessary, quality meets professionally recognized standards and the location where services were given is appropriate. PSROs will have authority for advance determination over elective admissions to hospitals and long-term-care facilities and over extended and costly treatments. The responsibilities initially may apply only to institutional care, but ultimately will apply to all health care under Medicare, Medi-Cal and Maternal and Child Health programs. A statewide professional standards review council will coordinate activities of all PSROs in the state and will help evaluate their performance.

### *CMA's Position*

When Congress was considering the Bennett Amendment to the Social Security laws, the California Medical Association strongly opposed its PSRO provisions, stressing "the tremendous amount of ongoing, organized effort by the medical profession in the area peer review and its conviction that no nationwide 'blanket' approach in this area would fit our needs in California[1]." It urged Congress to "allow states of proven capabilities in the area of peer review to continue to advance their quality and cost-monitoring systems, in concert with fiscal intermediaries and county societies[2]." Furthermore, CMA stressed the dangers to quality of care inherent in mechanisms concerned primarily with cost control.

When PSROs became law, the CMA Council voted to "continue to be a strong advocate in defense of the (medical) profession whenever regulations or administrative policy interferes with the practice of medicine[3]." CMA will continue to "support, encourage and strengthen its Peer Review Commission and all functions related to quality assurance, including: medical staff survey activity; development and publication of medical policy information; appeals committee activity; and continuing education programs."

The California Medical Association, "when requested, will offer full assistance to any society or its foundation which expresses an intent to establish a PSRO, but will not actively encourage those societies which do not seek to establish a PSRO to develop one. Instead, CMA will urge those societies to support and strengthen peer review as a medical society/association function. CMA will continue to support local jurisdiction over professional review and quality evaluation, and will offer advice and consultation to government in its development of regulations of the Bennett Amendment."

CMA House of Delegates agreed that "an effort should be made to establish a role for the Peer Review Commission which parallels that of the Statewide Professional Standards Review Council, while striving to become the primary coordinating resource to the Council[4]." CMA has launched an educational and information program regarding CMA's Peer Review Commission, the Bennett Amendment and PSROs to its membership and component societies, emphasizing person-to-person communications by physician leaders.

In addition, CMA is working with county medical societies to identify rational medical service area boundaries and a masterplan is being prepared to present these PSRO area preferences to the federal PSRO office.

Because medical care needs in California are both varied and complex, peer review continues to be a dominant theme with CMA. It is a dynamic, evolving process which the medical profession recognizes as its responsibility. This responsibility extends to all services provided by or ordered by physicians, and is equally applicable to various delivery systems ranging from solo practice to highly-structured, closed-panel approaches. CMA believes, however, that quality, not cost, must always be the paramount concern of physicians, in the best interests of their patients. (see "Quality Medical Care")

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# Quality Medical Care

*Peer Review, Continuing Medical Education*

MAINTAINING AND IMPROVING the quality of medical care have long been areas of intense concern for the medical profession. With increased demand for services and increased involvement by government and other third parties in the medical care field, the profession's quality assurance programs are essential activities in the public's behalf.

California physicians have developed an effective and nationally recognized system of "peer review" (described below). Peer review is defined as the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. As generally used, peer review is the all-inclusive term for professional medical review efforts, ranging from credentials review to disciplinary action when necessary.

Continuing medical education for the physician is another aspect of the profession's effort to assure high quality medical care. Here again, California physicians have developed a program considered a model for the nation (outlined below). Continuing medical education is defined as educational activities designed to reinforce the physician's basic medical knowledge and inform him of new developments within his field through refresher courses and supplemental study. The importance of this activity is underscored by the rapid progress of medical science—a doubling of medical knowledge approximately every seven years.

## *CMA's Position*

### *PEER REVIEW*

California Medical Association is firmly committed to the concept of peer review, because only practicing physicians are equipped by education, training and professional experience to evaluate the medical care provided by other practicing physicians.[1] Consequently, CMA sees peer review as the appropriate and essential function of state and county medical associations, hospital staffs and other physician sponsored organizations.[2]

How does a peer review work?

On the local level, qualifications or credentials committees maintained by county medical societies and hospital staffs investigate the credentials of all applicants for membership, make recommendations regarding membership and staff privileges, review records to arrive at a decision regarding performance and competence, and investigate any breach of ethics that may be reported. Patterns of practice and professional conduct questions are reviewed by the peer review and mediation committees of county medical societies. Foundations for medical care—and their work in local health insurance claims review—are an extension of that activity.

Within the hospital, doctors' diagnosis and treatment are reviewed by a variety of committees established by doctors. Tissue committees review the indications for surgery from reports on tissue taken during surgical procedures—and report evidence of unnecessary or questionable surgery. Utilization committees monitor the necessity and length of hospitalization. Medical procedures committees analyze medical procedures, including the medical management of surgical patients.

In 1971, a special commission was established by CMA[3] to expand, coordinate and refine physician peer review activities concerned with quality of medical care and utilization. CMA's Peer Review Commission assists local peer review groups, provides a central clearinghouse for peer review information, develops comparative data, administers appeals and assures public accountability. Most recently, CMA also established a Public

Advisory Council to provide information on the public's views concerning problems of health care quality and costs.

Our Medical Staff Survey Program is another CMA approach to assuring quality medical care. Since 1959, this voluntary program has been making thorough on-site reviews of hospital medical staff performance. Now also conducting surveys jointly with the Joint Commission on Accreditation of Hospitals (Consolidated Hospital Surveys), the program draws from a panel of 180 practicing physicians, as well as utilizing hospital administrators from the JCAH. Hospitals meeting the stringent survey standards are awarded seals of approval. A similar program of staff review for long-term care facilities was initiated recently by CMA.

### *CONTINUING MEDICAL EDUCATION*

The field of continuing medical education provides another example of CMA activities designed to assure high quality care to patients. Since 1934, CMA—in cooperation with the State's medical schools—has sponsored its own postgraduate education programs to keep physicians up to date. These and other programs now represent nearly 50,000 hours of instruction yearly in California. For many years, CMA also has served as a statewide center for coordinating and publishing of postgraduate medical education sponsored by a variety of participating organizations—hospitals, medical schools and so forth.

Recognizing that continuing medical education has become increasingly necessary "to enable the physician to render the best possible care for his patients in this day of rapidly expanding medical knowledge[4]," CMA officially launched a unique new program in 1970. It consists of "certification" for California physicians—regardless of CMA membership—who voluntarily participate in a minimum of 200 hours of approved postgraduate educational activities in a three-year period; already more than 10,000 doctors are voluntarily participating in the certification program.

A related program is CMA's "accreditation" of the continuing medical education activities of health facilities—the first state-level program of its type in the nation, and one which 31 other state medical associations have used as a model. The emphasis of this voluntary accreditation program is on improving the quality of continuing medical education, on making it responsive to the needs of practicing physicians and on making it effective as a means of improving patient care. Audit workshops in continuing medical education are held to assist hospitals in defining their educational needs and dealing with them effectively. Another important aspect of the accreditation process is an ongoing program of evaluation to determine that educational activities actually have been effective in improving patient care.

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